ST/ESA/245

PREVENTION OF SUICIDE

Guidelines for the formulation and implementation of national strategies

United Nations

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Department for Policy Coordination and Sustainable Development

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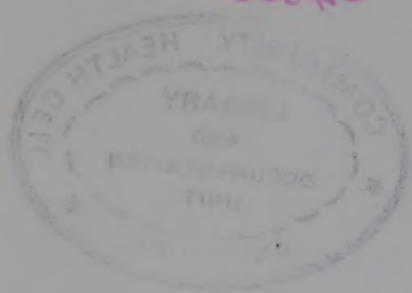

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PREFACE

In his first report made to the General Assembly at its forty-sixth session in 1991 on implementation of the Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future (A/46/414) the Secretary-General of the United Nations drew attention to the fact that suicide had been found to be a growing problem, particularly among youth, and that numerous innovative approaches were being made to deal with it and other growing problems associated with psychological stress. An example was given of the emergency first-aid suicide prevention training programmes for front-line caregivers of any discipline and occupational group, which had been developed by the University of Calgary in Alberta, Canada.

In his second report on implementation of the Guiding Principles, made to the General Assembly at its forty-eighth session in 1993 (A/48/56-E/1993/6), the Secretary-General, on the basis of conclusions which he had drawn after monitoring the situation during the period from May 1991 to October 1992, suggested that the General Assembly might wish to consider a number of courses of action which might be taken by Governments. One of them was to include social policy components within comprehensive national strategies for dealing with severe dysfunctional conditions, including anxiety, stress and suicide.

The monitoring process had revealed that many countries in Western Europe and North America, Australia, New Zealand and Japan lacked comprehensive national strategies for preventing and resolving many types of severe individual dysfunctional condition, including suicide. In Central and Eastern Europe, including the countries of the former USSR, monitoring had shown that stress, anxiety and suicide were rising rapidly. In many countries of Africa, Asia and Latin America there was some evidence, although rarely systematically investigated, that suicide was a significant and growing problem.

As part of its continuing programme of promoting the exchange of information and strengthening national policies in respect to the provision of individual-, family-, and community-oriented social welfare services to persons suffering from severe dysfunctional conditions and to other persons immediately affected by such conditions, undertaken pursuant to General Assembly resolutions 42/125, 44/65, 46/90 and 47/90, the Department for Policy Coordination and Sustainable Development of the United Nations Secretariat, together with the Division of Mental Health of the World Health Organization and the Calgary WHO Collaborating Centre for Research and Training in Mental Health, collaborated with a number of Canadian specialist organizations in the holding of the International Expert Meeting on Guidelines for the Formulation and Implementation of Comprehensive National Strategies for the Prevention of Suicidal Behaviour and the Provision of Supportive and Rehabilitative Services to Persons at Risk and to Other Affected Persons. The Meeting was held at Calgary and Banff, Alberta, Canada, from 25 to 29 May 1993.

Because very little has been published on the topic of comprehensive national-level approaches to suicide prevention, the Department for Policy Coordination and Sustainable Development considers it useful to make available the report of the Meeting. It includes a comprehensive set of guidelines, together with a case study of a national strategy, formulated recently in Finland, which is the only known example of a national strategy which attempts, within an integrated approach, to identify the functions of all relevant institutions, public and private.

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Part one

REPORT OF THE INTERREGIONAL EXPERT MEETING ON GUIDELINES FOR THE FORMULATION AND IMPLEMENTATION OF COMPREHENSIVE NATIONAL STRATEGIES FOR THE PREVENTION OF SUICIDAL BEHAVIOUR AND THE PROVISION OF SUPPORTIVE AND REHABILITATIVE SERVICES TO PERSONS AT RISK AND TO OTHER AFFECTED PERSONS

(Calgary and Banff, Alberta, Canada, 25-29 May 1993)

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INTRODUCTION

The Interregional Expert Meeting on Guidelines for the Formulation and Implementation of Comprehensive National Strategies for the Prevention of Suicidal Behaviour and the Provision of Supportive and Rehabilitative Services to Persons at Risk and to Other Affected Persons was held at Calgary and Banff, Alberta, Canada, from 25 to 29 May 1993. The Meeting was organized by the University of Calgary, Faculty of Social Work; Calgary General Hospital, Department of Psychiatry; Suicide Information and Education Centre; and Living Works Education, Inc., Calgary, Alberta, in collaboration with the Department for Policy Coordination and Sustainable Development of the United Nations Secretariat and the Calgary WHO Collaborating Centre for Research and Training in Mental Health.

Financial resources were provided by the Children's Bureau of Health and Welfare Canada; Alberta Health; Alberta Family and Social Services; Alberta Heritage Foundation for Medical Research; Canadian Mental Health Association, Alberta Division; University of Calgary, Faculty of Social Work; and Living Works Education, Inc.

The Division of Mental Health of the World Health Organization (WHO), the Department for Policy Coordination and Sustainable Development of the United Nations Secretariat and the International Affairs and Mental Health Division of Health and Welfare Canada contributed to preparations for the Meeting.

The objective of the Meeting was to develop guidelines for use by Governments and all concerned national and regional non-governmental organizations to use in formulating and then implementing effective national strategies for the prevention of suicide and suicidal behaviour and for the provision of supportive and rehabilitative services to persons at risk and other affected persons. It was also the objective to assist the international community, both intergovernmental and non-governmental, to develop measures and programmes of effective promotion and support for national efforts in this area of policy concern.

I. ORGANIZATION OF THE MEETING

A. *Opening*

The Meeting was opened with greetings from Dr. Ron Dyck, Provincial Suicidologist, Division of Mental Health, Alberta Health; Ms. Heather Holly, Associate Director, on behalf of Dr. Julio Arboleda-Florez, Director, Calgary WHO Collaborating Centre for Research in Mental Health; and Dr. Ray Thomlison, Dean, Faculty of Social Work, University of Calgary.

Dr. Morton M. Silverman, Department of Psychiatry, University of Chicago, delivered the keynote address: "Approaches to suicide prevention: a focus on models". His paper presented an overview of basic concepts and terminology used in prevention research. He compared and contrasted various preventive intervention models for their applicability to the prevention of suicide. The majority of the models were community-based and population-focused, as opposed to those designed for individual application. The major preventive models identified were public health, health promotion and injury control. Preventive interventions were also directed at environments (ecologies), the interfaces between the individual and his/her environment (transactions), and the processes and contexts that the individual experienced. A conceptual framework for constructing preventive intervention models was provided, and the applicability of the models to the prevention of suicidal behaviour was discussed.

The paper supported an attempt to integrate ecological models and transactional models into a transactional/ecological model which would expand the level of analysis beyond microsystems, mesosystems and macrosystems. The contribution of the model would be to offer an alternative way of viewing the phenomena of interactions between many various parts of a total ecological and psychological system. In the model, equal weight was placed not only on the transactions between child and parent, parent and society, and child and society but also on an analysis of the interactions between various macrosystems which might bypass or transcend any particular level of analysis. In other words, a transactional/ecological model would lend credence to an analysis of the interaction between two society-level institutions in terms of how that interaction might subsequently affect either the child or the parental system. The model would allow for analysis of interactions between persons in a population and in many different settings. It would also expand the focus to include the ways in which person/setting interactions were affected by relationships among settings, as well as the broader, macrosystemic contexts in which they existed.

The paper concluded with a recommendation that in the prevention of suicidal behaviour (based on current knowledge and levels of intervention technology), emphasis should be placed on practical first steps. Those steps included:

(*a*) Means/methods: limit access to lethal means by decreasing availability and increasing knowledge of the potential lethal impact, through public education;

(*b*) Psychotherapy: adequately treat all individuals with significant affective disorders, schizophrenia, alcoholism and other substance abuse, and severe personality disorders;

(*c*) Social networks: provide opportunities and resources for the development of social networks that would increase a sense of belonging, a sense of community, self-worth and self-esteem;

(*d*) Social norms: promote societal norms that value life and value the contribution of each and every individual to the maintenance, sustenance, and future of society as a clear message of support to its troubled members.

The representative of the Division of Mental Health, World Health Organization, conveyed a message from the Director-General and provided a brief overview of WHO as the United Nations organization specialized in matters related to health. WHO's main sources of information were national ministries of health, official relations with selected non-governmental organizations and a network of collaborating centres. WHO was firmly anchored in a public-health tradition based on epidemiology and action-oriented activities. The Division of Mental Health had evolved a methodology to identify and select priorities based on seven criteria: magnitude, severity, social importance, controllability, availability of resources, costs and institutional agreements. Based on those criteria, WHO had included suicide among its priorities, focusing on data collection, analysis and dissemination; legal aspects; and prevention. The strategy proposed by WHO was essentially based on the identification of groups "at risk" and on restricting access to methods of suicide. Suicide was

viewed by WHO as a multifaceted and complex phenomenon which evaded simplification; it carried several connotations and had multiple causes, a varied morphology and diverse impacts.

The representative commented upon the 11 more or less different conceptual models for the prevention of suicide reviewed in the keynote address. He pointed out that the review of so many models made it clear that no one model was clearly superior to the others. He reminded the Meeting that models were but theoretical tools, trying to describe or justify what one had done, did or intended to do; they were not the actions or interventions themselves.

The representative of the Department of Policy Coordination and Sustainable Development provided a brief overview of the United Nations interest in the topic of suicide, which arose from its mandate to promote the full implementation of the Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future, endorsed by the General Assembly in its resolution 42/125, which emphasized the need to reduce stress and anxiety and to prevent harmful behaviour. The United Nations was increasing its emphasis on the need for all aspects of national social policy to be organized in a coherent and integrated manner, an emphasis expressed in the General Assembly's decision to hold a World Summit for Social Development in early 1995. Specifically, the Department was interested in developing a set of guidelines designed to ensure strategic and comprehensive national and international approaches to social problems. The development of national strategy guidelines for suicide prevention and the provision of services to those at risk and those affected by suicidal behaviour was considered to be one important step in that direction.

The representative, commenting on the keynote address, expressed United Nations support for the emphasis upon community-based and population-focused prevention models. There was an increasing convergence towards a belief that individuals must be helped not only by specialists but primarily in the supportive context of their social surroundings. Because of the emphasis upon community response, there must be greater attention to the cultural context, to indigenous forms ensuring social solidarity, strengthening individual self-esteem and confidence, and defending the fabric of social life against negative external pressures.

B. *Attendance*

The Meeting was divided into two parts. Two days at the University of Calgary were devoted to formal presentations from the invited experts and were open to conference participants with an interest in suicide prevention. Three days at the Banff Centre focused on the development of a guideline for formulation and implementation of national strategies on the prevention of suicidal behaviour. The Meeting was attended by 14 persons, from Australia, Canada, China, Estonia, Finland, Hungary, the Netherlands, Nigeria, India, Japan, the United Arab Emirates, and the United States of America, serving in their individual capacities as experts. A total of 50 additional persons from Alberta, other parts of Canada, and other countries attended the first two days. Twenty-one persons attended the Banff portion of the meeting, including invited observers from Australia and Sweden and WHO and United Nations representatives (see annex I).

C. *Election of officers*

The Meeting elected the co-organizers, Dr. Bryan Tanney (Canada) and Prof. Richard Ramsay (Canada) as Chairperson and Rapporteur, respectively.

D. *Adoption of the agenda*

The following agenda was adopted:

1. Keynote address
2. Presentation of background papers
3. Election of the Chairperson and Rapporteur
4. Adoption of work schedule
5. Preparation of Guidelines
6. Closure of the Meeting

E. *Documentation*

Background papers had been prepared for the Meeting by invited experts and by the representatives of WHO and the United Nations (for a list of papers prepared by experts, see annex II).

F. *Adoption of the report*

At its final meeting, on 29 May 1993, the Meeting adopted its report, including the Guidelines. The participants urged transmittal of the report to the Secretary-General of the United Nations for consideration by the Commission on Social Development and to the Director-General of WHO for consideration by the World Health Assembly.

II. Country Statements

The discussion and the development of guidelines for the formulation and implementation of national strategies for the prevention of suicidal behaviour were energetically stimulated by the presentation of the background papers and the active participation of the experts, observers and participants at the Meeting. The following is a summary of the information provided in the national papers.

Australia. Suicide was the second most common cause of death among young males, although the rate for all ages had remained relatively constant since 1904, ranging from 12 to 14 per 100,000. The youth rate was one of the highest in the world, ranking second to Hungary in 1988. In 1991, for the first time in over 50 years, male suicides exceeded the number of motor vehicle accident deaths. Male suicide rates in young and elderly adults was high, with a trend in the direction of increasing rates among the young and decreasing among the elderly. Evidence of increasing incidence of suicide and suicide attempts among the Aborigines was a growing concern, since suicide was uncommon among those of traditional orientation. There was a paucity of data on the rate of attempted suicide in Australia. Australia had not had a national mental health policy until 1992. There were still no national or state policies on suicide prevention, although a number of uncoordinated federal and state strategies were under way. A Suicide Prevention Committee under the umbrella of the Mental Committee of the National Health and Medical Research Committee had been established. It hoped to influence national policy development and to recommend the establishment of an Australian centre for suicide research.

Canada. The historical development, evolution and present status of strategies in the province of Alberta and

Canada-wide were summarized. Suicide rates had been around 14 per 100,000 for the past several years. Rates were generally higher than the national rate in the province of Quebec and the western provinces. There had been numerous coordinated initiatives for preventing suicide in Canada—a federal State with responsibilities for health, social welfare and education divided between different levels of government—and in its provinces over the past two decades. Progress was measured against draft guidelines for the development and implementation of national and regional strategies for suicide prevention. At the national level, recommendations for action had been published since 1987, but no coordinating body or governmental "lead agency" had been active in implementing them. The recommendations had been updated in 1993. Various explanations for the lack of progress towards an active national strategy were considered. They included the absence of a national lobbying group, lack of societal recognition of suicide prevention as a priority in response to the lost human and economic resources, and the stigma still attached to suicidal behaviour within Canadian society.

In Alberta a strategy based on community-wide interventions that addressed education/training and coordination of community resources had been implemented between governmental and non-governmental organizations by means of cooperation over the past decade. Although a theoretical model of research, information dissemination, caregiver training and local resource networking had not been fully implemented, the information and training components had received international recognition. There was significant pressure for "hard" outcome evaluation as measured by a declining suicide rate.

China. In China's culture every individual shouldered the burden for regeneration of its people; therefore, everybody must cherish himself or herself and not engage in behaviour harmful to the self. The Chinese attitude towards suicidal behaviour was negative, because suicide might cause huge distress and grief for the survivors. The suicide prevention movement in China had begun at the beginning of the 1970s with open discussions on the problems of youth suicide. Research had focused on hospital admission and epidemiology studies. The suicide rates varied between 8 and 12 per 100,000 in urban areas and 20 and 30 in the rural areas. Suicide rates were highest among youth and the elderly. In addition to the commonly known methods of hanging, shooting, drug overdose and gas intoxication, organo-phosphorus insecticide intoxication was a serious problem in rural areas. A national coordinating organization for mental health issues had been established in collaboration with WHO. The emphasis of the organization on suicide prevention had to be strengthened. Non-governmental organizations such as the Chinese Association for Crisis Intervention needed to be part of a greater collaboration among professionals, non-professionals and other concerned persons involved in the formulation of national strategies.

Estonia. Suicide rates in Estonia during the twentieth century give a vivid picture of suicide as a social phenomenon. From the beginning of the century the rate fluctuated in accordance with periods of socio-political pressure and disturbance. It had been low during the social democratic revolution of 1905 and the period of Soviet occupation. Rates dropped during the First and Second World Wars. There had been a sharp increase between 1947 and Stalin's death in 1953. The rate dropped dramatically to 14 per 100,000 in 1955. During the Khrushchev era the rate increased to 32 and remained at that level during the "stagnation period" (1966-1984). In the first year of *perestroika* the rate dropped 25 per cent and continued to go down until 1989. However, since 1989, the rate had been increasing. Efforts to prevent suicide had been made since 1988 (establishment of telephone crisis lines). In 1989, suicide research began in the Estonia Medical Association. In 1993 the Estonia/Swedish Institute of Suicidology was established with the aim of teaching the population on several different levels (preventability of suicide, crisis intervention skills etc.), developing research work and establishing a library of information and publications. Board members of the Institute were high-level specialists, including the Ministers of Social and Health Care and of Education and Culture.

Finland. The rate of suicide had consistently been one of the highest in Europe. A particularly urgent aspect of the suicide problem was the increasing frequency of suicides committed by young people, especially young men. The process of developing a national suicide prevention strategy had begun with a large research phase in 1986. The Finnish strategy had developed a clearly stated conceptual frame of reference and model. The National Public Health Institute provided the research resources needed for monitoring the suicide mortality rate and evaluating the effects of background factors and preventive measures. The National Agency for Welfare and Health coordinated the implementation and follow-up at the national level in conjunction with provincial boards, health care districts and other authorities involved in prevention. The Ministry of Social Affairs and Health had elevated suicide prevention to a target of strategic importance in public health. The implementation strategy was based on sub-projects concerning specific target groups in cooperation with the principal stakeholders involved with those groups. Early results of the national strategy were available, and documentation of the Finnish strategy was available in English (see part two below).

Hungary. The suicide rate in Hungary had always been high—in fact, the highest in the world for the past 100 years. The highest ever recorded rate was 46 per 100,000 in 1985. The rate stabilized at a high level for the next three years. Suicide deaths were three times as high as road accident deaths. Two striking phenomena had characterized suicide trends in Hungary: the continuous increase, on one hand, and the originally high base-line rate, on the other. The first signs of decreasing rates appeared in the 1988 statistics, but they covered men only. The drop could be interpreted as the result of certain recent changes in the social-political system. The highest rates were among the elderly, for whom the social support network was very weak. Although suicide prevention was no longer hindered by ideological or political factors, the necessary resources were absent. Recommended guidelines for a national suicide prevention strategy would aim to improve general and special health care services; improve community-level mental health programmes; provide support for self-help programmes; organize special suicide prevention training courses for policemen, firemen, jailers and social workers; organize school prevention programmes; improve the data collection system; and increase support for research.

India. Suicide, which was still a crime in India, was on the increase. In 1990, 74,000 suicides had been reported. Male suicides were more frequent than female suicides,

but at a much smaller ratio than in many other countries: 58.8 per cent male to 41.2 per cent female. The highest number of suicides was in the group of those 18-30 years old. Poisoning, drowning, hanging and burning were the methods most used. Serious disease, quarrels with in-laws and spouses, and love affairs were the frequently reported causes. Incidence was higher in the states of West Bengal, Tamil Nadu and Kerala, the latter having the highest rate. Research on suicide needed to adopt a multivariate approach. There was need to go beyond the individual and include family and social factors in understanding the phenomenon of suicide, especially the cultural context and the socio-economic realities of the country. A national strategy needed to involve four key areas: (*a*) broad policies to sensitize policy makers and administrators of health facilities to the issue of suicide, review legislation and develop a data bank; (*b*) training modules for different professionals and volunteers, family life education programmes for young parents, interdisciplinary teams of experts to develop training modules, public awareness and stress management programmes; (*c*) improved community out-reach and networks of services; and (*d*) support for programme evaluation and for practice-based and longitudinal research.

Japan. After the Second World War, Japan had a high suicide rate, especially in the 1950s. Since then, the rate had been decreasing, despite various social trends and problems, such as an increasing divorce rate, development of nuclear families, collapse of pre-existing family systems, changes in traditional values, sharp increases in the incidence of drug abuse and crime, intensified competition in society and a widened gap between rich and poor. There were about 21,000 suicides every year in Japan, making the suicide rate about 17-18 per 100,000, which was not much higher than in some European countries. Contrary to world perceptions, Japanese young people did not have a higher suicide rate than American young males. In addition, the problems of suicide of the elderly and some characteristic forms of suicide found in Japan, such as *oyako-shinju* (parent-child suicide pact) and *inseki-jisatu* (suicide usually committed by a middle-aged man in order to take responsibility), were of significance. There was still a strong taboo towards suicide in Japan, and adequate social systems had not been established. Future strategies for suicide prevention were proposed: (*a*) reduce the strong resistance among the general public to consult a mental health professional; (*b*) require suicide prevention training courses for medical students and general practitioners; (*c*) develop community-based suicide prevention training courses and school-based suicide prevention programmes; (*d*) give special focus to the problem of suicide among the elderly; (*e*) provide psychological help for those affected by suicide; and (*f*) establish an international exchange of current research findings and experiences for suicide prevention.

Netherlands. In the Netherlands, as in many countries, suicide ranked among the top 10 causes of death for individuals of all ages and among the two or three leading causes of death for those aged 15-34 years. The rate of suicide was higher than that of death by traffic accidents. Parasuicide had been soaring in the country since the late 1950s and early 1960s, making it one of the most important reasons for hospital emergency admissions and hospital treatment for young people. The Committee on Suicide of the National Council of Health was established to promote, coordinate and support, on the national, regional and local levels, the development, implementation and evaluation of programmes for the prevention of suicidal behaviour and, where unavoidable, their subsequent effects. The Committee produced a comprehensive report in 1986 on the state of suicide. It concluded that current science-based knowledge did not yet allow for any definite recommendations with regard to specific strategies or methods for the prevention of suicide or suicidal behaviour. Some suicidal behaviour was thought to be prevented by current approaches, but no sufficiently hard and replicated data were yet available testifying to such an effect. The Secretary of Health published a national policy on suicide prevention in 1989, and four basic components of a national programme to be developed were identified: (*a*) promotion of research and data collection; (*b*) improvement of health care services; (*c*) provision of training and information to relevant organizations and groups as well as the general public; and (*d*) the promotion of care for groups at special risk.

Nigeria. In Nigeria and many other African countries, the major causes of death were infectious and water-borne diseases and malnutrition. Burdened with poor infrastructure, such as inadequate provision of potable water, and a shortage of trained public health personnel and services, African countries had taken little, if any, initiative in the area of suicide prevention. Suicide rates were thought to be generally lower than in developed countries, but there had been very little systematic study of suicide. Most of the few studies, done mostly by psychiatrists, had been on attempted suicide. They indicated that suicide prevention concepts and activities should be built into existing programmes—that is, in the training programmes of health workers, especially mental health workers; by strengthening the accident and emergency departments of general hospitals; and by enhancing a sense of belonging and interconnectedness which were inherent in the national culture.

United Arab Emirates. Arab and Muslim cultures did not view suicide as a problem. Their religion prohibited cessation of one's life, and their values perceived suicide as an offensive act that cursed the diseased and brought shame to the family, although in certain situations suicidal missions might be viewed as heroic acts and even blessed. In spite of the sanctions against suicide, suicide attempts and deaths did occur and were on the rise in the Persian Gulf region. The problem of suicide had received little research attention, and the actual prevalence of completed suicide was unknown. Only three studies were known to have been completed since the late 1970s: in Kuwait, the United Arab Emirates and Saudi Arabia. A study on youth overdoses was in progress in Bahrain, and for the past few years Egyptian psychiatrists had shown an interest in studying suicidal behaviour. What was known seemed to concur with findings in other countries: that the rate of completed suicide was higher among males than among females but that the parasuicide rate was higher among females. The most common method used was overdose, for both males and females. Other methods included burning (especially among females), drowning (especially among males) and poisoning (for both). In the United Arab Emirates the indigenous citizens did not constitute the majority of people residing in the country, but they made up the largest share (42.7 per cent) of cases of deliberate self-inflicted harm. Preventive strategies would span several

disciplines and involve community networks, voluntary action and self-help groups. Adequate communication between researchers and those who developed the interventions would be necessary. There was a need for authorities to promote research on suicidal behaviour and to affirm that there was no societal disgrace in revealing facts about it.

United States of America. The suicide rate had stabilized between 12-13 per 100,000 for the past several years. The suicide rate for young people between ages 15 and 24 had almost tripled during the past 30 years. Beginning in 1980, more than half of all suicides occurred among persons under the age of 40. A representative of the National Institute of Mental Health outlined the federal Government's view that suicide and other suicidal behaviour was an important public health problem. The prevention of the problem was guided by several recent national initiatives, including an overall national strategy for disease prevention and health promotion, a national youth suicide prevention strategy, a national injury control strategy and a science-based national public and professional awareness campaign focused on depression. The achievement of the goals stated in the strategies was dependent upon rigorous scientific research to identify modifiable causal mechanisms and to evaluate preventive interventions designed to modify those mechanisms for effectiveness and safety. A contemporary comprehensive formulation of the public health model provided a strong conceptual framework for research aimed at achieving national strategic goals. A representative of the Centers for Disease Control described the public health approach as a framework and method for reducing suicide and suicidal behaviour. The elements of the public health approach (health event surveillance, epidemiologic analysis and intervention/evaluation) were examined as they were implemented in the United States. It was suggested that each element of the public health approach could be refined and utilized more fully. There was need for integrating the separate elements into a single approach.

III. Conclusions

The Meeting drew specific conclusions in various areas of concern.

A. *The problem*

The Meeting concluded that:

(*a*) The behaviour appropriate for suicide prevention activities should be broadened to include suicide and attempted suicide or parasuicide;

(*b*) The incidence of suicide and attempted suicide appears to be rising in many societies, particularly affecting youth and the elderly;

(*c*) The principal causes of this phenomenon are multifaceted and originate throughout the entire fabric of society;

(*d*) Suicides, attempted suicides, and their impact upon affected persons constitute a socio-economic cost of increasing significance. More effective prevention will reduce the magnitude of the direct losses in human resources and expenditures in health, social and other services.

B. *Prevention*

The Meeting concluded that:

(*a*) Suicide is a preventable mode of death. Some perhaps a great deal of suicidal behaviour can be prevented through the provision of broad-based supportive and rehabilitative services to persons at risk and other affected persons;

(*b*) A holistic approach to prevention—one which includes bio-psycho-social elements and is systematic, goal-oriented and targeted at individuals, families and communities—is required to complement specific interventions for known at-risk groups;

(*c*) Few countries in the world have formulated and/or are implementing comprehensive national strategies in collaboration with non-governmental organizations and institutions. The majority of countries have no national strategies, relying primarily on the uncoordinated efforts of governmental agencies or non-governmental organizations, which usually have limited resources.

C. *Policy*

The Meeting concluded that:

(*a*) National Governments are acknowledged to have the sovereign right to set policy priorities on matters related to suicide. The formulation of national strategies for the prevention of suicide and other suicidal behaviour should be consistent with corresponding governmental policy;

(*b*) National Governments should be encouraged to articulate the relationship of their national policies for the prevention of suicide and other suicidal behaviour to their own institutional structures and processes responsible for individual, family and community well-being;

(*c*) National Governments should establish or designate a governmental or non-governmental coordinating body to be responsible for the prevention of suicidal behaviour.

D. *Procedures*

The Meeting concluded that:

(*a*) The appointed coordinating body should be given a mandate to identify and invite concerned groups from the public and private sectors to participate in the process of formulating a national strategy;

(*b*) The mandate of the coordinating body should include responsibilities for promoting, developing, implementing and coordinating activities leading to the achievement of national strategy objectives;

(*c*) National Governments should provide the coordinating body with executive, financial and technical resources to ensure effective and efficient formulation and subsequent achievement of national strategy objectives;

(*d*) The mandate should give the leadership of the coordinating body in charge of suicide prevention responsibility for formulating national strategies, guided by governmental policy, a supporting conceptual framework, general aims and goals, measurable objectives and a commitment to monitor and evaluate implemented programmes.

E. *Expectations*

The Meeting concluded that:

(*a*) The process of formulating comprehensive and coordinated strategies will itself constitute a means to mobilize available national and regional resources, including, but not limited to, institutional resources, and the promotion of a better awareness among the public, policy makers

and other specialists of the dimensions and seriousness of increasing rates of suicidal behaviour;

(*b*) Each national strategy will be formulated in harmony with the cultural, social and economic characteristics of each country and with the broad involvement of different sectors and segments of society, and should be implemented through appropriate programmes in all areas of prevention;

(*c*) Individuals and communities will possess the expertise to prevent suicidal behaviour if they are appropriately educated and trained and their activities coordinated and integrated at all levels;

(*d*) The detailed recommendations of the Meeting are formulated as Guidelines for the Formulation and Implementation of Comprehensive National Strategies for the Prevention of Suicidal Behaviour and the Provision of Supportive and Rehabilitative Services to Persons at Risk and to Other Affected Persons.

ANNEX I

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ANNEX II

Documentation

Asuni, Tolani. National strategies for suicide prevention in Nigeria.

Baume, Pierre. Suicide: an Australian perspective.

Csiszer, Nora. Suicide and suicide prevention in Hungary.

Deikstra, Rene. Report on suicide by the National Council on Health of the Netherlands.

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Shah, Gita. The problem of suicide and the provision of supportive and rehabilitative services to persons at risk and to other affected persons in India, with a special focus on regional or national efforts to establish national policy guidelines for the prevention of suicide.

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Tanney, Bryan. National and provincial experiences in developing and implementing a strategy for suicide prevention in Canada.

Upanne, Maila. Suicide can be prevented: A target and action strategy for suicide prevention in Finland.

Varnik, Airi. Suicide prevention strategies in Estonia.

Part two

GUIDELINES FOR THE FORMULATION AND IMPLEMENTATION OF COMPREHENSIVE NATIONAL STRATEGIES FOR PREVENTION OF SUICIDAL BEHAVIOUR AND THE PROVISION OF SUPPORTIVE AND REHABILITATIVE SERVICES TO PERSONS AT RISK AND TO OTHER AFFECTED PERSONS

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Introduction

These Guidelines were prepared to encourage action on national strategies in all countries, appropriate to their national circumstances, and to provide a means whereby the international community may support national efforts. The Guidelines were prepared for distribution to:

(*a*) All national Governments, through the United Nations and the World Health Organization (WHO);

(*b*) All concerned non-governmental organizations, institutions and individual specialists, through their representative organizations;

(*c*) The concerned public, including persons at risk and persons affected.

A clearly rising incidence of suicidal behaviour and a lack of comprehensive national strategies designed to deal with the situation have been identified in many countries. The international community, at both intergovernmental and non-governmental levels, has expressed its concern for more effective policies in the field of developmental social welfare. Those concerns were set forth in the Guiding Principles for Developmental Social Welfare Policies and Programmes in the Near Future, adopted at an Interregional Consultation on Developmental Social Welfare Policies and Programmes (E/CONF.80/10) in 1987, and endorsed by the General Assembly at its forty-second session, in 1987 (resolution 42/125). The Guiding Principles were reaffirmed in 1989 (resolution 44/65), and approved in 1991 as a major framework for action at the local, national, regional and interregional levels in developmental social welfare (resolution 46/90).

The targets and objectives of the Guiding Principles point out the need for social welfare programmes to give greater attention, among other things, to the effects of various types of harmful behaviour. The Secretary-General's report on monitoring the implementation of the Guiding Principles (A/48/56-E/1993/6) noted that the effects of harmful behaviour, including several other areas of concern, were in many ways more alarming in 1992 than in 1987. Although the validity of the Guiding Principles is still widely recognized, greater efforts are called for if acceptable global social well-being is to be achieved within a reasonable period of time.

Governments have increasingly acknowledged that social policy must be given much higher priority. Some Governments, although not yet the majority, have moved towards treating social issues comprehensively rather than sectorally. There is growing convergence in thinking among governmental agencies and concerned intergovernmental organizations, international non-governmental organizations and specialists that an effective social policy must comprise a number of mutually reinforcing emphases, which include the promotion and support of individual, family and community efforts to overcome dysfunctional conditions by means of strengthened social welfare services.

More and more countries are acknowledging that the direct and immediate costs to society of containing and compensating for individual dysfunction are very large and significantly exceed the cost of policy interventions designed to prevent or resolve such dysfunction. High levels of individual dysfunction in countries places severe constraints upon the desired realization of human resource potential, thereby preventing higher individual productivity, creativity and entrepreneurial effort.

These Guidelines address the need for Governments to approve national strategies for suicide prevention as a component part of their efforts to establish comprehensive national social policies.

I. Suicidal behaviour and its consequences

Suicide is a global tragedy. Each year at least 500,000 people are known to die by suicide. However, since suicide is seriously underreported in all countries, the actual number is certainly much higher. Estimates run as high as 1.2 million. Suicide is not only a problem of the highly industrialized, affluent societies in the northern hemisphere. It is a problem in both hemispheres, in developing and developed countries, and it occurs among all age groups and social classes.

Although there is large international variation in suicide mortality, the global picture for the past few decades has been one of rising trends. This has been particularly noted among the younger age groups, even though the highest rates are still found among the elderly.

One consequence of this development has been that in the majority of countries, suicide now ranks among the top 10 causes of death for individuals of all ages and among the three leading causes of death for adolescents and young adults. In some countries, suicide is the leading cause of death for those in their late twenties or early thirties. In many countries, the number of deaths from suicide is much higher than the number of deaths from motor vehicle accidents. This comparison also makes painfully clear that the suicide problem has been generally neglected or ignored all around the globe.

Suicidal behaviour statistics show that in addition to the number of suicides, at least 20 times as many persons make non-fatal suicide attempts serious enough to require medical attention, often resulting in irreversible disability. In many countries, suicide attempts are one of the main reasons for hospital emergency admissions and treatment of young people, putting a heavy burden on their health-care systems. The majority of individuals who attempt suicide tend to be adolescents and young adults, and together they form a pool from which many future suicides emerge.

In addition to the many millions of persons who, for reasons of social and emotional suffering and loss of hope, commit or attempt suicide, there are the innumerable others, such as family members, friends, colleagues, and care-givers, whose lives are profoundly affected. Given that for every suicide and suicide attempt, there are at least five persons intimately related to the individual in question, then each year many millions of survivors are added to the tens of millions of persons already struggling, often for many years, to cope with the impact of a suicide tragedy on their life and well-being.

Apart from the economic costs involved in providing a range of services to those who exhibit suicidal behaviour and the persons around them, there is also the fact that these individuals no longer contribute to the social and economic functioning of their communities. One measure of this is the calculation of years of productive life lost. It has been estimated that at a global level economic losses from suicidal behaviour amount to about 2.5 per cent of the total economic burden due to disease.

In most cases, the tragedy of suicide can be prevented. Major contributing factors such as mental and addictive

disorders, adverse social conditions, lack of supportive environments for individual development and the absence of appropriate services for people in need are often correctable. Rising to the challenge of preventing suicidal behaviour is the basic human motive behind the call for countries to develop national strategies for suicide prevention and for relevant organizations to assist them in this most needed and urgent endeavour.

II. Organizing principles

Acting on the premise that individual life has value and meaning, segments of societies have supported and organized suicide prevention activities for centuries. These Guidelines evolve from that body of work, representing a renewed and broadened approach to suicide prevention. The term "suicide prevention" here refers to all relevant activities which might reduce the morbidity, mortality and other consequences associated with suicidal behaviour. At all levels, actions directed towards the prevention of suicide should be based on objectives that can be evaluated for their effectiveness. These objectives flow from several goal statements and from a number of organizing principles, listed below. They are in harmony with existing principles but significantly expand both the focus of prevention efforts and the range of the actors, agencies and actions which can be considered.

(*a*) Suicidal behaviour and the conditions antecedent to it are the appropriate focus for prevention activities. This expansion of the field of interest includes completed suicide; attempted suicide, or parasuicide; and those conditions, states and disorders which proximally herald or predispose self-destructive behaviour;

(*b*) Employing a bio-psycho-social framework, the contexts of suicide are viewed from a broad perspective of human development. Suicidal behaviour is understood to be multifactorial, multidetermined and transactional in its origin and to develop cumulatively through identifiable, but complex, pathways or trajectories;

(*c*) No single discipline or level of social organization is solely responsible for suicide or for suicide prevention. As a consequence, the issues of and solutions to suicidal behaviour are appropriately acted on by everyone in the community. Both individuals and agencies are, within their areas of competence and capacity, empowered to act as part of a network of community-wide resources;

(*d*) Individuals in many roles and at all levels of community/society possess the expertise to make a unique and productive contribution to the prevention of suicidal behaviour;

(*e*) The mosaic of community resources for suicide prevention operates most effectively when its activities are coordinated and integrated. Collaboration at an intersectorial and interregional level, between government and non-governmental organizations and involving public- and private-sector contributions, is also of fundamental importance;

(*f*) A conceptual framework for understanding suicidal behaviour is needed to generate systematic and goal-oriented research and prevention activities;

(*g*) Equipping individuals, families and communities with the knowledge, skills and values to foster and maintain their general health and social well-being and that of their communities is essential. These universal activities directed towards all members of society should complement the continuing availability of specific interventions for known problem or at-risk groups;

(*h*) A convergence of experience and wisdom in many countries supports the belief that some—perhaps a great deal of—suicidal behaviour can be prevented.

The Guidelines offer a means of facilitating the development of national strategies for the prevention of suicidal behaviour within the socio-economic and cultural context of any interested country. They should not be considered explicit instructions to be followed by every Government. Each Government needs to adapt or modify specific components of the Guidelines to fit its own cultural, economic, demographic, political and social needs. The Guidelines should be revised periodically to reflect new knowledge in the field of suicide prevention and experience acquired during their implementation.

III. Objectives

Suicide is a behaviour with devastating effects on the cohesive fabric of society. The range of suicidal behaviour is broad and results in much pain, suffering and disruption in the lives of individuals, families and communities. The nature of the overall problem necessitates the development of strategies that reflect a holistic approach to prevention. This would ensure a comprehensive, coordinated and collaborative strategy to reduce the expression and consequences of suicidal behaviour.

The aim of a national strategy would be to promote, coordinate and support culturally appropriate intersectorial programmes for the prevention of suicidal behaviour at the national, regional and local levels.

The following goals cover the range of outcomes that would support the aim of a national strategy:

(*a*) Preventing premature death due to suicide across the life span;

(*b*) Reducing the incidence and prevalence of other suicidal behaviour;

(*c*) Reducing the morbidity associated with suicidal behaviour;

(*d*) Providing opportunities and settings to enhance resiliency, resourcefulness, respect and interconnectedness for individuals, families and communities.

The following types of activities and approaches constitute courses of action that could support the attainment of national strategy goals:

(*a*) Develop a national-specific conceptual framework for implementing, monitoring and evaluating suicide intervention programmes that address the specifics of the problem and fit the unique characteristics of the country;

(*b*) Adopt a standard taxonomy for suicidal behaviour;

(*c*) Promote the early identification, assessment, treatment and referral of persons at risk of suicidal behaviour for professional care;

(*d*) Increase public and professional access to information about all aspects of preventing suicidal behaviour;

(*e*) Promote and/or support the establishment of an integrated data collection system which serves to identify at-risk groups, individuals, situations and settings associated with life-threatening behaviour;

(*f*) Promote public awareness with regard to issues of mental well-being, suicidal behaviour, the consequences of stress and effective crisis management;

(*g*) Develop or maintain a comprehensive training programme for identified gate-keepers—e.g., police, educators, clergy, primary health care providers, mental health professionals and others;

(*h*) Where indicated, adopt culturally appropriate protocols for the public reporting of suicidal events;

(*i*) Promote increased access to comprehensive services for those at risk for, or affected by, the full range of suicidal behaviour;

(*j*) Provide supportive and rehabilitative services to persons affected by suicidal behaviour: persons who are at risk or who have attempted suicide, their family, friends, colleagues and other associates;

(*k*) Reduce the availability, accessibility and attractiveness of the means for suicidal behaviour;

(*l*) Identify and/or establish institutions or agencies to promote and coordinate research, training and service delivery with respect to suicidal behaviour;

(*m*) Develop or modify relevant legislation and administrative regulations to facilitate the implementation of national objectives.

IV. Formulation of a strategy

Given that a comprehensive national strategy exists in only a very few countries, the most important activity—likely to occupy the energies of concerned institutions and specialists, both governmental and private, in most countries, for a period of at least several years—is the actual formulation and adoption of national strategy objectives.

The value of developing a comprehensive national strategy is based on the assumption of broad involvement from different sectors and segments of society. This is well in line with the current trend observed in the production of policies of interest to a society which favours and stresses community-based activities and community involvement in the planning, implementation and evaluation of national programmes.

A national strategy for the prevention of suicidal behaviour must be linked to a corresponding policy declaration of a national Government. With the adoption of such a policy declaration, it is expected that a governmental agency or non-governmental organization would be designated and funded as the coordinating body responsible for the bio-psycho-social problems associated with suicidal behaviour. In countries that have institutional arrangements for the general well-being of their citizens, an existing body—public or private—will likely be appointed. In countries where such institutional arrangements are absent, it is expected that the Government will establish a coordinating body.

Experience has shown that the formulation of national strategies are more likely to succeed if they are guided by the inclusion of several basic elements:

(*a*) Government policy;

(*b*) Supporting conceptual framework;

(*c*) General aims and goals;

(*d*) Measurable objectives;

(e) Identification of agencies/community organizations to implement the objectives;

(*f*) Monitoring and evaluation.

A. *Initial study*

Once the coordinating body is appointed, one of its early activities will be to conduct or commission a systematic study of what is known about national trends in suicide and suicidal behaviour; to identify causal and correlational patterns; to evaluate the impact on those affected by suicidal behaviour; and to determine the available level of constructive support service to those at risk or affected. The coordinating body will also carefully review and determine the extent to which the basic elements of a national strategy are already in place.

B. *Initial drafts*

It is expected that the coordinating body will be given the responsibility to identify and invite the participation of interested groups from the public and private sectors in the process of formulating a national strategy. An initial meeting might be held of experts from all sectors who are known to be concerned about the problem of suicidal behaviour. The meeting might best consist of an informal and preliminary exchange of views. The coordinating body might undertake to establish a mechanism for requesting, receiving, reviewing and discussing the contributions of concerned individuals, groups and organizations. It would also seek to create an atmosphere of interest in developing a collaborative, comprehensive, intersectoral and multidisciplinary strategy based on a broad conceptual framework of general health and social well-being.

The coordinating body will undertake to draft the policy- and goal-oriented national strategy. The draft at this stage should deal primarily with a statement of general aims and goals and priority national objectives, in keeping with the policy interests of the national Government. It should be distributed to community-based individuals and representatives of community groups and organizations for comment.

With endorsement from the community-involved representatives, the coordinating body will submit the revised national strategy to the Government for approval.

C. *Procedures initiated by local communities*

Although governmental policy is necessary for the successful formulation of a strategy at the national, regional or local levels, suicidal behaviour, compared to other general public problems, may not be an issue of priority. In countries where this situation exists, it may be necessary for concerned individuals, groups or organizations at the community level to initiate steps towards the formulation of a national strategy. Appendix I provides a schematic outline of these steps and shows their linkage to the steps initiated by a Government after its decision to make the problem of suicidal behaviour a national policy priority.

V. Implementation

The success of the national strategy will entail the need to delegate institutional responsibility for transforming the objectives into reality. Thus, it is important for countries to articulate the relationship of the national strategy objectives to their specific institutional structures and processes.

The process of articulating these relationships should be facilitated by the coordinating body, which, in addition to its mandate to formulate the national strategy, should have a mandate to develop, implement and coordinate activities

leading to suicide prevention. The coordinating body would be responsible for developing or maintaining horizontal coordination across and vertical interaction among designated institutions, groups and individuals.

Countries that already have a coordinating body are encouraged to consider possibilities for broadening collaborative efforts with public- and private-sector coordinating bodies at different regional levels.

It is suggested that the coordinating body at this stage focus on identifying problems of implementation, by means of:

(*a*) Surveillance, to monitor the problem;

(*b*) Basic research, to identify risk factors;

(*c*) Programme development, to develop intervention programmes and services;

(*d*) Evaluation research, to develop means to test the effectiveness of interventions.

The process of strategy articulation and approval should be interactive and dynamic as progress towards addressing suicidal behaviour proceeds. It is advised that the coordinating body supervise implementation of the strategy in the areas of research, services, training and monitoring systems. Additionally, the coordinating body should initiate and encourage the involvement of a broad spectrum of institutions, groups and individuals within the society. The coordinating body should have a mandate to request international technical assistance if needed.

Governments are advised of the importance of providing the coordinating body with the executive, financial and technical resources that will enable it to carry out its formulation and implementation responsibilities effectively and efficiently.

VI. Relevant policy areas

The prevention of suicide and the provision of supportive, caring and rehabilitative services require numerous distinct efforts undertaken by different persons, groups and institutions, in a comprehensive but coordinated manner. Those efforts are likely to fall within the scope of certain policy areas, such as health, education, welfare, social services, legal services, police and so on).

Those responsible for actual formulation at the national level will have the task of drawing up appropriate plans for all populations at risk (e.g., persons in crisis, mentally disordered persons, and persons in correctional facilities). Within these Guidelines it would not be appropriate to provide detailed sets for all possible contingencies – that is, all populations at risk or all sectorial intervention areas. Appendix II, by way of example, sets out measures concerned with the increasing number of suicides committed by young persons, particularly young men. A special challenge in most countries is finding new means of coping for children and young people and alleviating injurious living conditions and situations.

VII. Publication and dissemination

Once the comprehensive national strategy for suicide prevention has been formulated by following the procedures outlined above, it should be published in full and made available to all interested institutions and persons, and to the public. It should be accompanied by detailed explanations of all of its components, if possible in the form of information kits designed to meet the likely needs of different categories of institutions and different categories of populations at risk. Wherever necessary, appropriate information should be made available in the separate languages of all residents, particularly in those of persons at high risk—for example, certain indigenous peoples or older immigrants.

In many circumstances it will be valuable to formulate and publish local or regional variants of the national plan, indicating in very specific terms the responsibilities of all concerned agencies. Provision of local information materials, including detailed information on the availability of local services and the means to contact various institutions, would be of value.

Good public information systems are needed because of the major importance given to: (*a*) promoting public awareness of the nature and causes of the problem, and the means to identify persons at risk; (*b*) providing quick-response preventive measures within the context of families, schools and workplaces; and (*c*) having rapid access to appropriate specialist institutions, if required. At the national level, the institution responsible for public information should designate a specialist sub-unit to disseminate suicide prevention information. At the regional and local levels, similar responsibility could be assigned to a specific organizational entity, public or private, involved in the prevention of suicidal behaviour.

VIII. Implementation, review and appraisal

The effectiveness of implementing any national strategy needs to be monitored from the very beginning. At the operational level, this involves the evaluation of the internal efficiency of individual projects and programmes in terms of their specific objectives. It also involves a more extensive evaluation of the impact that the activities appear to be making in changing societal conditions.

In most countries the national strategy on suicide prevention will be a new instrument. Consequently, it would be wise to allow sufficient time for the various measures to be carried out, evaluated and, if necessary, adjusted at the micro-level. Care should be taken to avoid a situation where a series of changes in the strategy are made more quickly than the ability of the various administrations to put them into effect.

IX. International promotion and support

International promotion and support of national strategies need to be evident without interfering with the right of any country to formulate a national policy appropriate to its circumstances.

Intergovernmental organizations, such as the United Nations and WHO, can provide assistance in making the Guidelines available to all Governments. In return, each Government can be requested to inform those organizations of its views and proposed actions. Specifically, the United Nations can provide a clearing-house function for the collection and publication of the national strategies from different countries. Additionally, it and WHO can be important sources of feedback to national strategy coordination bodies. They can provide ongoing support for the importance of incorporating a suicide prevention strategy into every country's comprehensive social policies, and they can provide technical support for countries that request assistance in the development and implementation of a national strategy.

52. International and national non-governmental organizations have a major role to play in sponsoring and hosting congresses to present and disseminate new knowledge and information about suicide prevention. The United Nations and WHO can maintain a constant dialogue, provide advice and act as a liaison with non-governmental organizations that may be able to provide specialist help to governmental efforts to develop a national strategy. Non-governmental organizations can assist national strategy coordination bodies through their efforts to keep the public well informed about the magnitude and severity of the problem, nationally and globally. They have important roles to play in providing technical and financial support for the assessment of the problem within a given country, and for the assistance they can provide in the development and implementation of national strategy plans. They have an especially important role in promoting the importance of research on culturally specific high risk factors and in the development of culturally appropriate preventive interventions.

ANNEX I

Local initiatives

In some countries, efforts to develop a national strategy of suicide prevention will begin at the community level. They might be initiated by individuals, grass-roots workers, ad hoc groups of concerned citizens or leading non-governmental organization interest groups.

Prior to a decision by the national Government to give policy-level priority to the prevention of suicide, the community is advised to take the following steps:

(*a*) Whoever initiates the process must undertake a review of existing knowledge about suicidal behaviour within the society. This will include definitions, magnitude of the problem, methods of suicide, services available for those at risk and those affected, and cultural attitudes towards the issue.

(*b*) The nature of the problems determined from the review must be translated into a statement or issue of concern that will attract the interest of policy makers and help them see the relevance of the problem to the well-being of the country;

(*c*) The initiators are advised to seek support from a coalition of interested parties in the country (local, regional, national or international in representation). The parties need to formulate a common declaration of intent among themselves to promote the need for a national strategy;

(*d*) The coalition should collectively review the existing knowledge on suicidal behaviour to make sure everyone is at a similar level of understanding and agreement on the nature of the problem. A detailed analysis of the problem should be prepared for distribution to members of the public and other potential supporters;

(*e*) A public awareness strategy, using public forums, media coverage and print campaigns, should be activated to broaden public support for a national strategy;

(*f*) Members of the coalition should jointly organize a culturally acceptable plan to lobby, petition and influence governmental policy makers of the need to give policy-level priority to the problem;

(*g*) As part of their plan to influence governmental policy, members of the coalition should prepare a proposed national strategy and/or provide examples of national strategies used in other countries as information for the policy makers;

(*h*) The coalition will need to devise short- and long-term steps to sustain their plan of influence until the Government develops a national policy position.

After the national Government has decided to give policy-level priority for the prevention of suicide, the following steps are recommended:

(*a*) The coalition may need to develop a further plan to sustain the Government's interest in the problem until it appoints a coordinating body responsible for the formulation and implementation of a national strategy;

(*b*) The national Government agrees to the formulation of a national strategy on suicide prevention consistent with its policy-level priorities;

(*c*) The national Government establishes or designates a governmental/non-governmental coordinating body responsible for the prevention of suicidal behaviour;

(*d*) The appointed coordinating body is given a mandate to identify and invite concerned groups from the public and private sectors to participate in the process of formulating a national strategy;

(*e*) The mandate of the coordinating body is broad enough to include responsibilities for promoting, developing, implementing and coordinating activities leading to the achievement of national strategy objectives;

(*f*) The national Government provides the coordinating body with executive, financial and technical resources to ensure effective and efficient formulation and subsequent achievement of national strategy objectives;

(*g*) The coordinating body takes the necessary steps to formulate a national strategy for governmental approval, guided by governmental policy, a supporting conceptual framework, general aims and goals, measurable objectives and a mandate to monitor and evaluate implemented programmes;

(*h*) Strategies are implemented through appropriate programmes in all areas of prevention and with broad involvement from different sectors and segments of the country.

ANNEX II

Prevention of suicide among youth

The measures outlined below might be appropriate for a substrategy concerning youth. With appropriate modifications, they could be applied to other populations at risk.

(*a*) The provision of adult nurturing, basic health care, nutrition, shelter, educational and occupational opportunities and protection against all forms of violence should be recognized as components of a comprehensive prevention strategy against a wide range of serious problems. Networks of community resources should be established for this purpose;

(*b*) Children and young people should be supported by their families and communities in order to enable them to exercise over their lives control that is culturally and developmentally appropriate, to increase their self-esteem and effectively to cope with problems. Parenting skills training, including the use of appropriate disciplinary practices to promote the dignity of the child, should be offered. Children and youth should be provided with age-appropriate opportunities to increase feelings of mastery, responsibility and interpersonal problem-solving skills. A chance to finish school should be secured for all children and youth;

(*c*) Every suicide attempt by a young person should be investigated, and appropriate support and treatment must be provided for them and their families. Multidisciplinary expertise should be employed in these activities. Furthermore, because suicidal behaviour is often chronic, a well-organized structure of follow-up should be established for high-risk youth;

(*d*) Research aimed at the identification and investigation of high-risk groups among youth should be encouraged and financed by Governments and by non-governmental and business organizations in the private sector. Risk groups include those who have attempted suicide, have mental and addictive disorders (e.g. depression, conduct disorders, schizophrenia, alcohol and other drug abuse disorders), are isolated from the community or have experienced loss (death of a parent, parental divorce, unemployment, failure in academic performance, etc.);

(*e*) Identification of high-risk groups could be facilitated by public and professional awareness programmes about mental and addictive disorders, the related warning signs of suicidal behaviour, and effective treatments currently available. Early identification of mental and addictive disorders, and appropriate treatment for them, should be emphasized. Programmes should be carefully tailored to each population. Every effort should be made to decrease the stigma against suicidal behaviour;

(*f*) Reducing the availability and accessibility of lethal methods of suicide should be considered on an individual, community, regional and nationwide basis;

(*g*) A statistical analysis of national mortality data indicates that cluster suicides occur predominantly among adolescents and young adults and that such clusters account for approximately 1-5 per cent of all suicides in this age group. Therefore, when a death (accidental or suicide) occurs, appropriate measures should be taken immediately for the prevention of suicide clusters. The importance of establishing in advance a cooperative relationship with the mass media should be emphasized. Otherwise, a suicide cluster might develop as a consequence of the exaggeration or glorification of suicide in the media;

(*h*) After a suicide, services should be available to provide psychological and social support help to the victim's significant others (family, friends, relatives etc.).

ANNEX III

Developing a conceptual framework

Developing a framework to guide the formulation and implementation of guidelines for the prevention of suicidal behaviour and the provision of support and rehabilitative services to those affected, based on current knowledge and levels of intervention technology, should be practical in nature. The framework adopted by a national Government should allow for easy identification of intervention targets. In a traditional public health model, "host" (potential suicide victims) groups can be fairly easily identified—for example, at-risk populations and those who attempt suicide. At the "environment" level, contributing variables can be identified, including social support resources, economical factors, legal sanctions and community attitudes that are associated with the increased vulnerability of host groups. At the "agent" level, the means and methods of inflicting self-injury are variables that can be targeted, to decrease availability (i.e., gun control) or to increase knowledge of the potential lethal nature of the means (i.e., harmful effects of "overdoses" in low amounts).

For each intervention target, the framework should provide for multiple levels of responsibility and implementation, ranging from the actions of individuals to the involvement of international organizations. The framework also should provide for steps to be taken. The traditional prevention model, for example, provides for primary, secondary and tertiary forms of intervention. Primary interventions would try to minimize the risks of resorting to self-injury. For example, by adequately treating all individuals with significant affective disorders, schizophrenia, alcoholism and other substance abuse problems or severe personality disorders, the incidence of suicides and suicide attempts would dramatically decrease. Secondary prevention would include early detection and treatment of contemplated or planned self-injury. The adequate training of all front-line health and mental health caregivers would increase the detection of and provision of appropriate support for individuals actively contemplating suicide. Tertiary prevention would be aimed at those affected by the suicidal actions of others. Social support services to family, friends and colleagues would reduce the number of survivors who are often isolated from the normal grieving process. The advance preparation of policy guidelines by communities and institutions (i.e., schools) to deal with the impact of death by suicide would greatly increase the effectiveness of responsible leaders to provide supportive services when large numbers are affected by a suicide.

Part three

THE FINNISH TARGET AND ACTION STRATEGY FOR SUICIDE PREVENTION

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PREFACE

The Finnish National Research and Development Centre for Welfare and Health published the following strategy in the form of a booklet in 1993 for wide circulation in Finland. It was prepared by Maila Upanne and Helena Arinpera in collaboration with an expert group for suicide prevention appointed by the National Board of Health (subsequently the National Agency for Welfare and Health). The booklet was submitted to the Interregional Expert Meeting on Guidelines for the Formulation and Implementation of Comprehensive National Strategies for the Prevention of Suicidal Behaviour and the Provision of Supportive and Rehabilitative Services to Persons at Risk and to Other Affected Persons, held in Alberta, Canada in May 1993.

INTRODUCTION

Since 1986 a research project has been examining the nature of suicide in Finland and developing measures to prevent it. Initially, all suicide cases from the previous years were examined. Project groups appointed at the provincial level then studied the findings and recommended various preventive measures. In all, over 1,000 researchers, planners and specialists in several fields have contributed to the strategy. The central findings of the project, "Itsemurhat Suomessa 1987" (Suicides in Finland in 1987), are presented in a separate report. More detailed information on motives, background factors and contexts has been published by the National Agency for Welfare and Health.

The strategy distills and summarizes the main challenges that emerged during the project. It highlights, in systematic format, the factors which tend to play an important role in the course of a life terminating in suicide.

The most striking observation made during the project was the great variety of phenomena that can exert cumulative effects in a life ending in suicide. Significant contributory factors come into play in different phases and areas of life.

It also became obvious that discretion and jurisdiction in suicide prevention activities tend to vary and overlap among numerous different authorities. The bedrock for practical suicide prevention in Finland is the presence of various bodies in society which will shoulder the responsibility, make the commitment and do their utmost to cooperate. Genuine authority and influence in suicide prevention depends on specialist knowledge in various fields, and on responsibility and commitment.

The main purpose of this booklet is to clarify the fundamental policies and goals which will foster and guide the development of suicide prevention policy in Finland. For the sake of clarity, the various challenges needing to be tackled are dealt with separately, although factors contributing to suicide do, of course, interact in a person's life. It is essential for different authorities to share a common resolve in this issue and for preventive measures to be streamlined and well coordinated.

This booklet is thus designed to be used in the following ways:

(*a*) As a basis for public discussion;

(*b*) To assist in decision making;

(*c*) As a catalyst for organizing activities;

(*d*) to stimulate information transfer;

(*e*) As an impulse to reviewing current services and practices;

(*f*) When planning further education;

(*g*) In everyday discussions.

The issues and ideas presented need to be discussed within different sectors of relevant administrations and professional bodies. It is important for discussions to relate to everyday life situations, and material on various themes is being compiled for that purpose. Some of the tasks identified in the strategy are to be carried out by interdepartmental cooperation at the national level or by the National Agency for Welfare and Health. It is this final stage of the project which will determine the real nature and efficacy of suicide prevention in Finland in the years ahead.

I. PRINCIPLES OF SUICIDE PREVENTION

A. *A life ending in suicide has borne a cumulative burden*

The project findings indicate that suicide is a result of a long, sometimes even life-long, process. Little by little the problems accumulate until they finally seem insurmountable, although at the end, suicide always happens suddenly and is rarely predicted by others. In retrospect, the factors and events identified as significant can be zoned according to their proximity to the suicide or to how big a risk they formed. Observations indicate that beyond the circumstances which directly precede suicide (specific factors) lie other contributory factors which have definite but indirect links with it. In unfavourable circumstances these so-called non-specific factors act to increase the probability of suicide. However, equally important are positive circumstances which, if they prevail, tend to counteract the processes leading to suicide (constructive and protective factors).

In preventive work all contributory factors are regarded as important targets. The more indirect they are, the more easily the relevant prevention measures can be incorporated into other social activities, in order to minimize disruption and supplement resources. The essential point here

is to become aware of the positive opportunities for preventive activities which exist in everyday life situations, in addition to the harmful and disempowering circumstances and experiences of life.

B. *What does preventing suicide mean?*

Suicide prevention includes a range of activities aimed at influencing the factors and events proved to be significant in life processes culminating in suicide.

Preventing suicide means influencing, in a corrective and constructive way, the process of problem development and the individual's own resources at different phases of life, in order to:

(*a*) Prevent suicide from occurring;

(*b*) Prevent problems from worsening and becoming insurmountable—e.g., by supporting coping resources;

(*c*) Prevent the circumstances or factor interactions which lead to problems;

(*d*) Teach individuals to manage their own lives, while offering alternatives and support when needed.

The principles of preventive activities can thus be summarized as follows:

(*a*) Eliminate or reduce the influence of factors that directly increase the possibility of suicide;

(*b*) Eliminate or reduce the effects of difficulties and problems that, in unfavourable circumstances, could lead to suicide;

(*c*) Create circumstances and experiences that improve the individual's options for controlling his own life and which support his own resources for coping.

Society has to decide whether it wants to intervene via intensive treatment when the problems are already severe or through more minor measures at an earlier stage to prevent problems from taking control in the first place. This choice partly reflects society's view of how the individual and her life should develop, how problems emerge, worsen and become resolved etc. It is possible to influence an individual's destiny and to prevent problems from escalating into crises. Knowledge of the circumstances and experiences that tend towards suicide allows society's choice to be exercised.

C. *The challenge of negative attitudes*

Public discussion tends to reveal a number of negative attitudes and beliefs which form obstacles to suicide prevention, for example:

(*a*) If it's going to happen, it will;

(*b*) When problems are that big, you can't expect to do anything about them anymore;

(*c*) You can't really change a person's circumstances and experiences anyway;

(*d*) Everyone makes his own choices, and other people shouldn't interfere;

(*e*) These people have such enormous problems that it's not even worth believing they can be helped;

(*f*) There has always been a lot of suicide in Finland; it's because of our national character. Besides, there are plenty of suicides in other countries, too;

(*g*) A person must have the right to decide on his own life or death.

II. Suicide prevention as a strategy of joint responsibility

It is possible to reverse the rising suicide rate if:

(*a*) Everyone who has attempted suicide receives help that is as effective as possible;

(*b*) Depression is recognized and the depressed person offered all the support he/she needs: everyone suffering from serious depression should get appropriate and effective treatment;

(*c*) The use of alcohol as a universal solution to problems can be prevented and better means of supporting efforts to cope can be found;

(*d*) Mental and social support are enhanced within the treatment of somatic illness;

(*e*) A person in a life crisis receives appropriate support from relatives and friends and from professionals, when necessary;

(*f*) The risk of youngsters becoming alienated from life can be avoided, and individuals running a risk of suicide are guaranteed the possibility of coping and improving their self-esteem;

(*g*) The cultural climate in Finland, education system included, becomes more relaxed and permissive and less guilt-promoting, stigmatizing and punitive than it tends to be at present. It needs to promote belief in life, resourcefulness, self-esteem, initiative and mutual support.

This can be achieved now, not sometime in the future. The research project supplied the data from which our picture of the typical Finnish suicide has taken shape. However, this information covered only the main areas and is naturally biased to some extent by the methods used. Thus, many of the detailed connections and interactions between various factors affecting the course of a person's life remain to be clarified. The more indirectly they are linked with suicide, the more open to interpretation is their significance. The picture to emerge must be considered in its cultural context. Further research is still needed, although the nature of the problem means it is unrealistic to anticipate precise, unambiguous solutions from scientific studies alone.

In any case, merely knowing facts about suicide is obviously insufficient for solving the problem. The essential point here is whether the factual knowledge and increased activity which this project has generated can be used to initiate social reforms. We have a "window of opportunity". Probably never again shall we have the chance to implement a large-scale, nationwide project of this type in Finland. Finnish society must make the decisions now. What kinds of resources and how much commitment do we need and how much are we able to devote to tackling this problem?

It needs to be clearly understood that suicide numbers cannot be reduced at a single stroke or even by measures taken by a single sector of society. The model presented here needs to be understood as a strategy for a spectrum of activities involving several sectors of society. Only in this manner will we be able to evolve functional solutions to the problems raised. Each sector of society concerned needs to appreciate its particular roles, duties and potentials in relation to the issues brought forward in the strategy.

The early 1990s are not an easy time to be implementing a strategy of this scope and size. Moreover, it exposes to us all a deeply disturbing aspect of contemporary life,

urgently highlighting the role of society and demanding our support for those at present and future risk of taking their own lives. The challenges present in suicide prevention work ultimately all derive from the disappointments of life and the difficulties in coping with them—whatever the apparent or expressed "reason". The current economic depression highlights the need for practical and specialist psychological help for people in life crises and for more optimistic attitudes towards the crisis resolution measures in suicide prevention.

Final decisions on implementing the strategy take place at the regional and municipal levels. Across Finland there is considerable variation in suicide rates and in many important background factors. The project findings are available on a regional basis, and the challenges presented by the strategy are subject to both regional and municipal decision-making. This means that implementation of the action programme has to occur according to regional systems of planning and decision-making.

The targets will be realized at a national level, if:

(*a*) Municipalities take the recommendations into consideration in organizing social and health services and if they control the supply, quality and diversity of these services and of any local factors connected to the problem. Above all, it is important to ensure that problems due to a life crisis that is resolvable receive adequate support. This goal applies particularly to schoolchildren and youngsters; people who unexpectedly face a "dead end"; or near relatives and close friends of persons who have committed suicide. Successful achievement of the goal must be planned in connection with the purchase of certain services. Special attention needs to be given to young people's circumstances and their capacities for coping, in order to minimize the risk of alienation;

(*b*) Health care districts and municipal federations for public health prepare targets and an action plan to cover the most pressing issues they are responsible for. Supplementary services that reduce risks and the burden on medical services will be categorized as benefits;

(*c*) Provincial boards define their own role and strategy for implementing suicide prevention activities within their jurisdiction. In collaboration with the relevant authorities throughout the province, each provincial board (or a planning group appointed by it) needs to prepare a plan that stresses the most important targets from its perspective;

(*d*) The National Public Health Institute contributes to the strategy by providing the research resources needed for monitoring the suicide mortality rate and evaluating the effects of background factors and preventive measures;

(*e*) The National Agency for Welfare and Health coordinates implementation and follow-up at the national level in conjunction with provincial boards, health care districts and other authorities involved in prevention. It will monitor the practical work of these authorities, cooperate in their activities, gather information on suicide prevention plans, and draw up nationwide reports, when needed. Data on suicide mortality rates (from the National Public Health Institute) and suicide prevention will be published from time to time;

(*f*) The Ministry of Social Affairs and Health elevates suicide prevention to a level of strategic importance to public health and monitors developments in suicide mortality and prevention.

III. Social and cultural issues

Although social and cultural factors can be important contributors to suicide, the indirect nature of effects makes it very hard to prove causal connections. Particularly careful research is necessary in this field. In the meantime, however, the fact that these issues are already established in the realm of public discussion means that some progress has taken place.

Many recent official reports claim that the psychological ability to cope with crises is an individual's most valuable resource and a major precondition for returning to a functioning life afterwards. Yet this recognition has still not been incorporated into any plan for action, nor considered in decision-making. Has the concept merely been poorly explained, or is it simply not acceptable after all?

The clear significance of various forms of alienation in lives culminating in suicide forces the conclusion that measures and decisions concerning prevention can be effectively realized only in a social context.

The psychological capacity to cope with crises must be recognized and installed as a special priority in developing prevention activities, equally important to other accepted prerequisites for maintaining the functional capacities for life. Issues relating to the coping capacity of the individual which have emerged from the projects should be subject to public debate. This will help to establish agreed minimum prerequisites for psychological coping abilities. The current economic depression places even greater urgency on our ability to evolve new coping skills, to stimulate fresh belief in life and human dignity, and to encourage new forms of mutual help and caring. The process of alienation among youngsters, especially boys, needs close scrutiny. We also have to find ways of enhancing young people's coping potential and help them find their place in life.

An urgent task we all share is to develop a clear understanding of how the Finnish man views himself, other people and life in general. The poorer ability of men to cope with personal crisis needs public discussion and formulation as a priority for activities and reforms. Men must learn to find relevant approaches and appropriate ways of solving the kinds of problems that have emerged during this project. The media, the experts and the opinion formers should all campaign on this theme.

The mass media in Finland dominate the evolution of cultural attitudes and the orientation of public discussion. We need to reshape public attitudes towards suicide and stop talking in ways which tend to confirm the opinion that suicide is an unavoidable aspect of our national culture or—worse still—a reasonable way of escaping from severe crisis. Have we in Finland begun to regard suicide as a kind of ordeal of initiation? Do some of us perhaps go so far as to consider suicide a model solution for crisis resolution, while discounting the role of support, crisis management etc.? Is the overwhelming dominance of negative criteria in news and current affairs programmes creating an atmosphere in which we find ourselves almost proud of the high Finnish suicide rate?

The media should face up to their responsibility by reconsidering their editing policy for handling these matters. Being in the service of the nation's citizens implies a duty to promote constructive alternatives, creative options and positive life values. Moreover, when suicide is discussed in the media we must remember that the audience may well include people currently at acute risk of suicide.

Social services need to revise their policy and approach. Another section of this strategy covers areas that need agreement on joint plans and shared responsibilities, such as those required by the Mental Health Act. In this respect the current economic difficulties may act as a productive challenge which ultimately generates great benefits for people and the quality of services. We need to ensure that staff in both public and private services are able to recognize the signs of an impending personal crisis even in the early stages. We must learn to interpret and help solve people's problems—especially those of children and youngsters—in a more real-life perspective. People and their problems need to be handled inclusively, with appropriate measures taken accordingly and with greater willingness to consult others.

Action is needed to ensure that problems manageable through minor measures are not left to deteriorate to the point of needing health care. The Mental Health Act requires health care districts to finalize the organization of prevention activities and follow-up, recruitment and the allocation of resources. Minimum requirements for prevention activities are defined in the strategy, as are the most vital targets. All preventive measures found to reduce the need for treatment must be recorded.

Specialist services must commit themselves to improving the functioning capacity of their target communities, such as schools and workplaces. These, in turn, should introduce new activities to promote coping skills and understanding. Resources need to be developed through successful social activities and interactions, and then implemented. Overall, we should learn to orient our energies more towards methods for avoiding the emergence of unnecessary problems.

IV. Coping in daily life

Suicide is a sign of an insurmountable crisis which in most cases would have been manageable with the intervention of expert help. For this reason the strategy places great emphasis on the responsibilities of specialist services. Nevertheless, we live in the privacy of a world of our own making, and the events and experiences of life form the substance of our reality. This being the case, are not the circumstances of our daily life the most obvious target for action if we wish to enhance people's capacities to cope?

Public discussion should be informed and educated about the range of potentials in the ordinary person for strengthening his own and his fellow citizens' self-esteem and ability to cope with life.

Creating a culture emphasizing joint responsibility, the virtues of perseverance and coping, and a spirit of mutual help and care, presupposes that these issues will be discussed in the mass media, among various social groups and in schools; mutual help and cooperative activities between people and within peer groups will be supported and encouraged; and the various projects will continue to compile and develop supplementary materials.

The National Agency for Welfare and Health compiles material explaining principles and practical measures for helping people at risk of suicide, and for supporting those in crisis and guiding them in how to cope with problems. This material is designed for information, education and discussion, and is to be tailored and produced for different social groups.

The National Agency for Welfare and Health, in cooperation with media representatives, will identify the crucial issues to be considered in the public debate of problems, crisis management and suicide. The material produced will form the basis for discussions.

We expect organizations and representatives of various social groups to begin discussing and incorporating into their activities the aspects of the strategy which are relevant and important to them, employing the help of specialists, when necessary.

The specialist services must intensify measures for supporting people's problem-solving skills, their ability to adapt, to persevere, to discover new options and to cope with crises.

V. Suicide prevention in decision-making, special services and community activities

This section of the strategy begins with issues directly connected with suicide risk and then covers indirect contributory factors. The main features of each issue are also arranged the same way: the challenges tackled first are always those directly associated with the possibility of suicide, even though the others can be equally crucial when they help people avoid situations that might end in crisis. So, for urgent challenges the beginning of each section should be read, and for preventive issues, the latter parts. For every recommendation, at least one responsible authority or the relevant category of institution is identified, in parentheses.

Cooperation between authorities, organizations and volunteers in various fields is clearly essential if we intend to achieve these goals. Knowledge and skills in the relevant fields need to be utilized in a more effective manner than at present. The development of regional strategy models, intersectoral work-sharing and mutual consultation will help us to attain these goals and simultaneously to optimize the use of available resources.

A. *Suicide attempted and intended*

An attempted or intended suicide always implies that the person has reached a dead end in his/her life and is desperate. But it does not always mean that the person absolutely wants to die, even if the attempt does end in death. It is possible to prevent attempted suicide and to avoid it, if the risk is recognized, the gravity of the situation is understood and adequate measures are found.

Recommendation 1

The life circumstances of each person attempting suicide should be investigated and appropriate treatment arranged (hospitals, primary care centres, psychiatric units, units for the care of intoxicant abusers):

(*a*) An initial contact unit will conduct the investigation and motivate the patient for future care;

(*b*) Specialist knowledge in different fields will be called on, if available and where necessary, during the investigation;

(*c*) The initial treatment unit then assumes responsibility for contact with the patient and maintaining his/her motivation;

(*d*) A functioning supportive network will be built up of relatives, friends and members of the nursing staff.

Recommendation 2

The organization for treating attempted suicide or those at risk should be planned and operated jointly by the local and regional authorities identified:

(*a*) Regional health-care organizations/units will agree on the distribution of work and the mutual transfer of information and will develop appropriate regional models of treatment methods (hospital districts);

(*b*) A uniform system of diagnosis and follow-up will be created, with special focus on the number and nature of attempted suicides (hospital districts, National Public Health Institute);

(*c*) The principles of the strategy and the methods of treatment of attempted suicides will be revised cooperatively at the national level (National Agency for Welfare and Health, hospital districts);

Recommendation 3

The skills and commitment of personnel treating attempted and potential suicides should be improved (hospitals, primary care centres, psychiatric units, other health care units):

(*a*) Basic knowledge of treatment methods and the mental readiness and skills of staff will be augmented to help them investigate the circumstances of self-destructive individuals, to motivate and refer them for further treatment, and to evaluate the severity of self-destructive behaviour;

(*b*) Staff members' commitment and initiative will be strengthened and they will be encouraged to participate in the treatment of self-destructive patients via outside or mutual job guidance work;

(*c*) Each suicide committed during a treatment period will be discussed by the staff from several viewpoints: contributory factors, treatment process, feelings of guilt and conclusions to be drawn;

(*d*) The ability of the ordinary citizen to judge the risk of suicide and to support a near relative or close friend at risk will be enhanced.

Recommendation 4

Discussion, supervision and restrictions are necessary to ensure that typical instruments of suicide are not easily accessible, especially to those at risk:

(*a*) Gun licensing is to be further restricted, and the power to cancel a current license will be used more readily. There will be careful scrutiny of each application and case (police);

(*b*) Citizens will receive more information about the storage of guns and ammunition at home, to minimize their access by young or intoxicated individuals (police, mass media);

(*c*) When sales licenses for drugs, especially psychopharmacological preparations, are being considered, the toxic properties of the substance must be taken into particular consideration (National Agency for Welfare and Health);

(*d*) When medication is prescribed, the risk of suicide, the toxicity of the drug and the appropriate dosage must all be estimated more carefully than before (medical profession);

(*e*) Physical structures and supervision in health care units will be inspected and any defects eliminated, particularly in psychiatric wards, hospitals, primary care centres and institutions for the elderly;

(*f*) The possibility of making it harder to use exhaust gas as a means of suicide is being investigated (Ministry of Transport Car Registration Centre, Technical Research Centre).

B. *Intoxicant problems*

There is cumulative interaction between intoxicant use and the prevalence of problems in a person's life. Although alcohol seems initially to ease problems, increasing consumption itself generates more problems and intensifies dead-end situations, in extreme cases to the point of suicide. While treating patients for intoxicant abuse, we should also be able to recognize and help resolve their underlying problems. Moreover, measures that reduce alcohol use play a useful role in lowering the risk of suicide among the population in general.

Recommendation 1

Staff faced with an intoxicant abuser experiencing crisis, and thus at risk of suicide, must be able to recognize the predicament and ensure that the person is guided into adequate treatment and support:

(*a*) Potentials for coping and the need for support, especially following a major loss such as divorce, need to be assessed (health care, welfare/care of intoxicant abusers);

(*b*) The unit that initially recognizes the crisis should take responsibility for handling the case, making sure the patient is referred to appropriate treatment or hospital etc., when necessary (health care, welfare/care of intoxicant abusers, police, primary care centres);

(*c*) Those in acute crisis resulting from offences committed while intoxicated will be informed of treatment options and the circumstances actively investigated (welfare/care of intoxicant abusers, police, primary care centres).

Recommendation 2

Intoxicant-related depression should be diagnosed and the patient should receive appropriate treatment from welfare and health authorities, in cooperation. Therapy and treatment models will evolve through specialist work (health care centres, welfare/care of intoxicant abusers).

Recommendation 3

The system of treatment and supportive services for intoxicant problems should be made more efficient:

(*a*) Health authorities and those caring for intoxicant abusers will resolve any areas of confusion (e.g., over responsibility) and plan the sharing of work and responsibilities within the municipalities and/or their federations;

(*b*) Services offered by occupational health care and non-professional organizations will be planned to complement each other and operate as support networks in the municipalities (welfare, primary care, specialized psychiatric care, occupational health care, organizations for intoxicant matters).

(*c*) Emergency and withdrawal services will be expanded, and their efficiency improved (welfare/care of intoxicant abusers, primary care);

(*d*) Staff members will become more qualified, in knowledge and attitude, to recognize and support persons with intoxicant problems, especially during associated crises (occupational health care, health care);

(*e*) There needs to be continuing public discussion of intoxicant abuse and its management—e.g., problems in the treatment and support system, treatment ideologies, negative feelings and biased attitudes towards intoxicant abuse (welfare and health care);

(*f*) The responsibility of the patient, and his/her family and friends, to seek help should be emphasized in cases where the patient is unable to control the use of intoxicants or to solve his/her problems (welfare and health care, organizations for intoxicant matters).

Recommendation 4

More support for the children of those affected by alcohol abuse is needed so as to strengthen their resources for coping. One way to achieve this is via contact persons, hobby circles, recreational pursuits etc. (welfare/child welfare, care of intoxicant abusers, primary care centres/child health centres, organizations for child welfare).

Recommendation 5

An incipient intoxicant problem should be recognized and the appropriate solutions activated before the situation becomes unmanageable:

(*a*) Methods for recognizing drinking problems will be improved and developed and active measures to support a patient's coping ability will be used and new types of activity evolved (occupational and student health care, primary care);

(*b*) The process of referral is to be used more for clarifying the situation than merely for transferring problems elsewhere (care of intoxicant abusers, primary care, specialized psychiatric care, occupational health care, organizations for intoxicant matters, workplaces/working units).

Recommendation 6

Policy measures aimed at reducing overall consumption of alcohol in society should receive more support.

C. *Mental problems*

People suffering from mental disorders run a higher risk of suicide than others. Depression, alcohol addiction, schizophrenia and personality disorders are particularly significant risks. In Finland, depression is often a central contributing factor in suicide cases. Moreover, a depressed individual often has other burdens to bear, such as somatic illness and intoxicant problems. Thus depression often comes into the picture in various circumstances and at different stages of life.

When treating mental disorders, the prospect of suicide must always be taken into account. There needs to be careful developmental work into how the treatment of depression can be intensified in order to prevent neglect which might lead unnecessarily to suicide.

Recommendation 1

The possibility of suicide should be considered in treatment of people with mental disorders. Assessment of suicide risk will be intensified at the start of treatment, when methods are changed or when the person responsible for the treatment changes (specialized psychiatric care unit, other health and welfare units, private therapists, private clinics).

Recommendation 2

Methods of recognizing depression and principles for treating it should be revised and improved (specialized psychiatric care units, other health and welfare units, private therapists and private clinics). Each treatment unit for depressive patients will check:

(*a*) That their recognition and treatment practices are comprehensive and effective;

(*b*) That all appropriate pharmaco-therapeutic measures are being used;

(*c*) Potential defects in the system: is it possible that a depressed patient might not receive the appropriate treatment? Could the policy or practice lead to circumstances that actually increase the risk of suicide?

(*d*) How assessment and risk reduction are incorporated into the treatment.

Recommendation 3

The public health care and social welfare systems should plan their cooperation and responsibilities for treating depression according to the nature and severity of the patients' problems (specialized psychiatric care units, other health and welfare units, private therapists, private clinics and volunteer and patients' organizations).

(*a*) Agreement on the distribution of work between different service systems should be reached and a differentiated treatment model created, according to the severity of the depression;

(*b*) The work of volunteers and patient organizations and the support of family members should be taken into consideration in treatment planning.

Recommendation 4

More training for recognizing depression and assessing suicide risk should be included in basic and further training of welfare and health care personnel (health care and welfare units, vocational institutions, universities and the National Board of Education).

Recommendation 5

Materials for the improved treatment of depression should be compiled, and development and research activities initiated at the national level (National Agency for Welfare and Health and the National Public Health Institute).

D. *Somatic illness*

Chronic illness or disability always tests a person's ability to adapt to unfavourable circumstances and to cope with an ordeal. Many people succumb to depression and lack the strength to find ways to cope. Thus somatic illness can sometimes be the start of a process culminating in suicide; indeed, even the fear of falling ill or of the condition worsening is occasionally enough. In the midst of terrible chronic pain, life can sometimes become unbearable. But by recognizing such crises and helping the person to cope, with practical support, tragedy can be avoided.

Recommendation 1

Serious illness is understood as a crisis that demands careful assessment of the patient's life circumstances and ability to cope. The assessment should be made in cooperation with the patient. Arrangements for adequate and appropriate psycho-social support are necessary (health care and welfare units).

Recommendation 2

In serious illness the following matters should be taken into consideration, in addition to the possibility of depression and suicide risk (hospitals, other specialized units for somatic care, private health institutes, private clinics and medical professionals).

(*a*) Is there sufficient pain relief?

(*b*) Is the patient mentally prepared for treatment that could provoke fear?

(*c*) Is the patient sufficiently informed as to treatment, prognosis and course of the disease?

(*d*) The patient needs to be guaranteed continuity of treatment and support. A contact person is necessary when the patient is transferred to another unit.

Recommendation 3

Staff members' ability to identify mental crises of various kinds and to operate interactively when treating somatic patients should be enhanced by further education and guidance (welfare and health care units, welfare and health colleges, universities and the National Board of Education).

Recommendation 4

The relevant supportive networks and friendship services rendered by volunteers and citizens' organizations should be improved and expanded (citizens' organizations and the information media).

E. *Life crises*

In a crisis situation, difficulties tend to culminate in a unique manner for every individual. In unfavourable circumstances any crisis can become an insurmountable experience. Breaking off vital social relationships, falling seriously ill or experiencing a crisis at work is often a decisive catalyst for a process leading to a dead end, especially for men.

Crisis sometimes causes people to act carelessly and harmfully towards themselves. This can itself initiate a process leading to further difficulties and eventually to suicide. Therefore people in crisis should not be left without help and support.

Recommendation 1

A suicide in one's immediate circle always needs to be discussed in cooperation with close persons or professionals (primary care, church, child and family guidance clinics and specialized psychiatric care units).

(*a*) The appropriate services in various sectors should be prepared to offer the support and treatment needed by people in a suicide's immediate circle;

(*b*) Agreement on the distribution of support work should be reached between local and regional authorities.

Recommendation 2

For divorce cases or serious family problems, mental and other forms of support must be arranged (National Agency for Welfare and Health, welfare, child and family guidance clinics, primary care, family counselling centres).

(*a*) Family counselling and therapy for family crises need to be improved and applied. These services should be made more generally accessible;

(*b*) Emergency services for individuals in acute crisis, especially men, will be created (health care).

Recommendation 3

People falling seriously ill must receive the support needed for adapting and coping (health care).

Recommendation 4

A comprehensive system of service organizations for crisis management has to evolve on both local and regional bases (hospital districts, primary care, welfare units, specialized psychiatric care units, other health care units, churches, hot lines and volunteers).

(*a*) Each organization should have at its disposal the necessary resources (time, personnel, skills) for managing crisis situations in its own area;

(*b*) The functions of municipal and health care district organizations are to be amalgamated to ensure a tiered system of services which is also easily accessible in emergencies;

(*c*) Public, private and volunteer services will be used to construct this system.

Recommendation 5

Negative consequences of significant changes in a person's working life should be minimized; this particularly concerns employees, employers and the general working community (workplaces, working units, occupational health care and labour protection).

(*a*) Mental adaptability to such changes should be encouraged;

(*b*) An emergency service for crisis situations is needed.

Recommendation 6

Occupational health care experts should be monitoring developments in working communities and encouraging resources for coping, with a view to releasing their positive energies (occupational health care).

Recommendation 7

Forms of cooperation and mutual help for coping with life's difficulties should be developed via various services, organizations and volunteer work. Cooperation among men is a particular priority (National Agency for Welfare and Health, welfare and health care, mass media, citizens' organizations and volunteers).

Recommendation 8

Various information channels and health education formats need to be developed to enhance people's psychological resources for coping and their self-help abilities in crisis situations (National Agency for Welfare and Health, welfare and health care, mass media, citizens' organizations and volunteers).

F. *Accumulated life problems*

Many suicide victims have lived in circumstances which can be characterized as underprivileged—materially, socially and psychologically. Often they have also had health problems. In many cases their difficulties began to emerge early in life. Unfavourable circumstances and lack of support and encouragement shape the course of their lives and set the stage for their overwhelming problems. In other cases the difficulties began to accumulate later on, so that the person feels that life is totally meaningless, or that he/she has no future and is not strong enough to solve

his/her problems. Various types of measures, both one-to-one interactions and social activities, are needed to prevent people becoming alienated and to lighten their burden of problems. The responsibility for prevention thus lies with many different authorities and social groups, some of which are mentioned in this booklet.

Recommendation 1

Mortality from suicide should be monitored as the critical indicator; conclusions will be drawn from the factors considered to be determining variables; and necessary measures for preventing suicide will be taken at the municipal, regional and national levels (municipalities, provincial boards, National Health Institute, National Agency for Welfare and Health, Ministry of Social Affairs and Health, Ministry of Finance and Ministry of Justice).

Recommendation 2

Supportive measures should be directed towards alleviating personal crises connected to the current economic depression by:

(*a*) Providing emergency financial and therapeutic help at the time of crisis;

(*b*) Clarifying responsibility for activities to resolve new types of problems (municipalities, welfare, health care);

(*c*) Seeking solutions to insurmountable difficulties due to excessive debts;

(*d*) New forms of cooperation between people in similar predicaments, and personal initiatives encouraged (financial institutions, Pensions Security Fund, citizens' organizations, municipalities, mass media).

Recommendation 3

The process of alienation and of problem accumulation needs to be identified and understood. Methods for arresting the process, finding solutions and promoting experiences of success and coping need to be made more effective (occupational health care, welfare/care of intoxicant abusers, psychiatric units, labour policy, workplaces, working units, unions and municipalities).

(*a*) Municipalities will take responsibility for managing intoxicant and other psycho-social problems in the early stages, for planning and coordinating adequate support and treatment, and for developing various forms of cooperation;

(*b*) Measures must be taken to improve the circumstances of the unemployed and their families;

(*c*) Activities to help people retain their working capacity and fortify their coping abilities will be increased;

(*d*) New alternatives (e.g., small homes) will be sought to improve the housing conditions of those who have difficulties in living in normal accommodation;

(*e*) Young peoples' opportunities for independence will be enhanced by improved access to available accommodation and jobs.

Recommendation 4

Children and youngsters must be helped to break out of the vicious cycle of failure and helped to acquire positive attitudes, human dignity, responsibility and coping skills (homes, schools, youth work and church youth work).

Recommendation 5

Feelings of basic security need to be enhanced for children and youngsters from disadvantaged backgrounds, in addition to permanent relationships and a satisfactory environment for their upbringing (welfare/child welfare, child/family guidance clinics):

(*a*) A child's needs at different stages of life must be considered paramount and unnecessary changes of foster homes avoided, when measures for his/her welfare are being planned;

(*b*) Both child and parents should be guaranteed adequate help during the process of placement in a foster home, to help them both cope with separation anxiety and sorrow.

Recommendation 6

The importance of joint responsibility and a healthy coping mentality should be emphasized in the mass media, as well as in child guidance, welfare and health care work (welfare and health care, mass media).

G. *Young people*

A particularly urgent aspect of the suicide problem is the increasing frequency of suicides committed by young people, especially young men. A significant number of these suicides are known to have resulted from a crushing sense of insurmountable problems which could often have been mitigated by simple measures. Although some of the problems have been serious, they could have been solved and the course of life changed if they had been recognized early enough and the person had received adequate support. So a special challenge, in addition to helping those in acute crisis, is to find new measures of coping for children and youngsters and to alleviate harmful living conditions and circumstances.

Recommendation 1

The backgrounds of youngsters who have attempted suicide need to be thoroughly investigated and the necessary support and treatment arranged for them. Psycho-social expertise from different fields must be employed in these investigations (hospitals, primary care, specialized units for youth psychiatry, child/family guidance clinics, school health care).

Recommendation 2

Every sign of self-destructive behaviour in young people should be taken seriously and attempts made to reduce the number of contributing factors and to alleviate their effects (homes, schools, school health care, youth policy, youth organizations, health and welfare units, church, National Agency for Welfare and Health).

(*a*) Individuals closest to youngsters and those living in the same environment are responsible for supporting them and for recruiting professional help when needed;

(*b*) A guidebook on help and support for youngsters will be compiled by a group of specialists.

Recommendation 3

A youngster's mental ill-health needs to be recognized at an early stage and interpreted correctly:

(*a*) Various forms of mutual support and help involving close individuals should be developed (homes, school health care, youth policy, citizen organizations, churches);

(*b*) Professional and other services providing help and support should be tailored to the requirements of young people, for both acute and longer-term problems;

(*c*) Aid in crisis situations must be quickly and easily available, especially to relatives or close friends of a suicide victim (specialized units for youth psychiatry, child and family guidance clinics, school health care, health centres, youth policy, churches).

Recommendation 4

In cases of family crisis or chronic problems, special support is to be arranged for children and youngsters:

(*a*) Systems of family counselling should be developed, and support activities enabling families to cope should be intensified (welfare services, child and family guidance clinics, family counselling centres);

(*b*) New measures should be developed for helping in cases of domestic violence (welfare, police);

(*c*) New working methods in child welfare should be developed—e.g., for situations when children are taken into custody or placed in foster homes (welfare services, child welfare organizations).

Recommendation 5

Children and youngsters need more support in gaining control over their lives, strengthening their self-esteem and coping with their problems:

(*a*) There needs to be more awareness in upbringing of the different impacts of punishment or supportive methods used at times of crisis, the aim being to foster constructive experiences;

(*b*) At home, at school and in youth work, children and youngsters need more exposure to constructive problem-solving, which increases their sense of responsibility, fortifies their self-esteem and supplements their mental resources (homes, schools, youth policy, welfare/day care, child welfare policy, churches, special youth organizations);

(*c*) Young people's capabilities for solving problems, especially those occurring in human relationships, must be enhanced (homes, day care institutions, schools);

(*d*) The option of completing their schooling must be secured for young people (schools, youth policy, youth welfare institutions, prison administration).

Recommendation 6

Public discussion of military conscription and the civilian service option is needed in relation to their influence in helping young men discipline their lives and improve their ability to cope with stress. Those who are exempted from military service or fail to complete it should be assessed, and appropriate support provided, where necessary (armed forces, primary care, specialized units for youth psychiatry and municipalities).

Recommendation 7

Basic material security for young families and individuals about to become independent has to be understood as a fundamental factor for preventing serious problems and suicide (municipalities)

Recommendation 8

The integration of young people into working life in appropriate ways needs to be secured through legislation (Labour Ministry, municipalities).

H. *The elderly*

Being "forced" to retire, being left alone, feeling one's life empty, falling ill, being under threat of institutionalization—all these can characterize a situation in which suicide appears the only alternative for a person growing old.

An elderly person running the risk of suicide often regards his situation as intolerable, although this interpretation can often be easily alleviated through appropriate practical rearrangements and support. To what extent are we ready to eliminate such difficulties to ensure our elderly folk a worthwhile life with maximal self-sufficiency? The answer to this is a revealing indicator of the true humanity in our society.

Recommendation 1

The risk of suicide in the elderly must be recognized and action always taken to reduce it, when discovered. The existence of any suicide plans by individuals who have fallen seriously ill or experienced severe disruptions in their lives will be investigated.

Recommendation 2

Depression in elderly folk needs to be diagnosed, and arrangements for adequate treatment made (homes, primary care, welfare/old-age welfare, other welfare units, churches).

Recommendation 3

Action should be taken to improve elderly people's prospects and coping abilities for taking responsibility for their lives, particularly in situations of radical change:

(*a*) Psychological and practical support and information will be offered to help reduce the mental burden of somatic illness and other disruptions to life (health centres, specialized units for somatic care, hospitals, institutions for the elderly);

(*b*) Activities for preparing older people for retirement will be extended (workplaces, institutions for adult education, National Pensions institutions);

(*c*) Opportunities for social interaction will be arranged to minimize loneliness and isolation (welfare/old-age welfare, churches, citizens' organizations);

(*d*) Maximal independence should be offered to people in institutional care (homes and institutions for the elderly, primary care, welfare and health units);

(*e*) Relatives will be encouraged and supported to take more care of their elderly folk.

Recommendation 4

Old age needs to be promoted by the media and public service bodies as a valuable phase of life, opening up fresh prospects and perspectives (homes, welfare and health care, mass media).

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